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Supporting an ethnic minority woman's choice for pain relief in labour: A reflection

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Abstract

Despite professional expectations for midwives to provide care to women that is founded in equality and recognises diversity (Nursing and Midwifery Council, 2015), women from ethnic minority populations consistently suggest that they are not heard (Briscoe and Lavender, 2009; Tobin et al, 2014). This article reflects upon a situation where a Portuguese woman with limited English speaking ability was denied access to epidural anaesthesia as the midwife felt that she could not give valid consent to the procedure without the presence of an interpreter. The midwife's role within this situation will be reflected upon and implications for midwifery practice identified.

Key words: ethnic groups; informed consent; midwifery; prenatal education

Communication is seldom thought of as a high priority instrument in improving maternal outcomes, however when it is timely, fitting to the situation and meets the individual needs of the woman and the health-care team, it can make a significant difference (Bick, 2010). Effective communication between mothers and healthcare professionals is fundamental to the provision of safe optimised care (Hayes et al, 2011). It is the origin of best practice, not only within midwifery but within all disciplines (Price, 2012). When providing individualised, holistic care to women, it is imperative to consider their cultural identity and needs (McCarthy et al, 2013). Inadequate and poorly organised maternity services, complicated by lack of education in cultural understanding and inconsistent access to interpreter services often has a detrimental effect on care provision (Tobin et al, 2014).

This article will reflect on a clinical situation where a midwife was caring for a Portuguese primigravid woman in established labour. The woman had a poor grasp of the English language. The midwife attempted to contact interpreter services to assist her during her labour but to no avail. Visibly distressed, the woman appeared to be signalling that she wished to have an epidural. The midwife caring for her declined access to an epidural as she believed the woman would be unable to consent in the absence of an interpreter. Following birth, once the interpreter was available, it was indeed confirmed that the woman was attempting to request an epidural. The reasons why her request was not granted were explained to her and she accepted the rationale behind the midwife's decision. The woman's acceptance of the situation may have been due to the fact that she progressed quickly to a normal vaginal birth rather than a prolonged situation, however, the implications within this situation warrant consideration to establish the evidence behind the midwife's decision making and to explore care of ethnic minority women within maternity services.

With one quarter of United Kingdom (UK) births attributed to women from outside the UK, there are very real implications for midwives in relation to promoting and developing supportive maternity service relationships with ethnic minority women (Office for National Statistics, 2014). Reports from the Confidential Enquiries into maternal deaths have identified disproportionately higher mortality rates in the ethnic minority population (Hayes et al, 2011). There are consistent messages which suggest these women do not receive optimal care and thus have a high risk of morbidity and death (Ameh and van de Broek, 2008).

The care provided during pregnancy and childbirth is of great value in every culture, yet, people of migrant origin often experience barriers to obtaining accessible, good quality healthcare in contrast to people of the host society (Lakhani, 2008; Malin and Gissler, 2009). Becoming a

mother, whilst attempting to adjust and settle into a new culture, can be a major challenge (Benza and Liamputtong, 2014). Like the majority of childbearing women, the woman herself desires a midwife who will listen to her, offer compassionate understanding, be genuine and not judge her (England and Morgan, 2012). All National Health Service clients, regardless of where they live, the country of their birth or their ethnic origin, have the right to expect equal and fair access to primary health care services that are responsive to their needs (Lakhni, 2008).

What is the purpose of informed consent?

In this case the midwife declined to permit the mother to receive epidural analgesia on the basis that she was unable to give informed consent to the procedure. The purpose of informed consent is to provide protection of the client's autonomy and integrity (Marshall, 2000). Morally, consent enables an autonomous person to choose what treatment they will agree to or refuse (White and Seery, 2008). National Institute of Clinical Excellence (NICE) (2007) proposes if a woman does not have the capacity to make decisions, healthcare professionals ought to follow the Department of Health reference guide to consent (2009). These guidelines identify it is a legal and ethical standard that valid consent ought to be achieved prior to commencing treatment for a person and go on to state if healthcare professionals do not obtain consent, and the client goes on to suffer harm as a result of the intervention, this may result in a claim of negligence against the healthcare professional involved (Department of Health, 2009).

Midwifery 2020 acknowledged migrant women who do not speak English as a first language to be a vulnerable group with complex needs (Midwifery 2020 UK Programme, 2010). Obstetric care to the migrant population gives rise to numerous challenges for the healthcare system (Hayes et al, 2011). Mc Court and Pearce (2000) suggest that a lack of high quality maternity care for ethnic minority women is a result of the institutional organisation of care; and

recommend alternatives such as the caseload model of care is made available as a choice to facilitate more women centred care. Beake et al (2013) found that caseload midwifery in a multi-ethnic community has the potential not only for improved quality of care but also improved safety.

The word 'midwife' is literally translated as 'with woman', and working within this literal translation, most women welcome having an active participation in the process of their care, the possibility of a choice and feeling in control during their childbearing event (Borrelli, 2014). The capacity to decision make is based on a woman understanding and using information about treatment when making a decision (Griffith, 2011). However, no individual has the right to accept or decline medical treatment on behalf of another unless they have specific legal authority to do so (Hayes et al, 2011). Working in accordance with the NMC Code (2015) midwives must be able to demonstrate that they have acted in the best interests of their client when providing care in an emergency.

Helping ethnic minority women to have a voice

Despite an expectation within the Code (NMC, 2015) in relation to promoting equality and diversity, ethnic minority women consistently suggest that they are not heard or believed, identifying control to be a major factor as they feel that the midwife attempts to control their knowledge, choice and even ability to give birth (Cross-Sudworth, 2007). People of ethnic minorities are often fearful of healthcare workers because they are not confident in speaking assertively and with authority in the native language (Van Servellen, 2009). Compassion, empathy and kindness are equally as important in intrapartum care as the ability to manage physical skills such as epidural analgesia (Curtin, 2014). Midwives must become politically and socially aware to make equality in healthcare a reality for vulnerable women (Ukoko, 2005). It is

suggested that ethnic minority representation on maternity services liaison committees is imperative in ensuring their needs are taken into consideration when providing services (Schott and Henley, 1996).

A recent enquiry into maternal deaths recommended professional interpretation services should be provided for all pregnant women who do not speak English and highlighted the lack of availability of suitable interpreters as an influential factor in poor outcomes (Centre for Maternal and Child Enquiries, 2011). Securing interpreter services for women in labour is challenging due to the unpredictable timing of the onset and also duration of labour, as was the case in this situation (Fetters et al, 2007). Healthcare providers are often influenced by hectic working conditions when deciding whether professional language assistance is needed (Kale and Syed, 2010). Although communication and language barriers between clients and healthcare workers are prevalent, few studies document what healthcare workers do when they encounter language obstacles (Kale and Syed, 2010). Tobin et al (2014) carried out a study to explore the childbirth experience of ethnic minority women in Ireland and found that whilst women commented positively on the kindness and care they received from healthcare providers, there was an evident lack of education and awareness of staff which was complicated at times by ignorance.

Utilising antenatal opportunities to discuss advance care directives for labour and birth

Marshall (2000) recommended that discussions with women about the advantages and disadvantages of intrapartum procedures should take place during the antenatal period. This is supported by Sonwalker and Hawthorne (2002) who declare that women ought to receive sufficient information in order to make an informed decision irrespective of race or language, and go on to question if anaesthetists should have contact with women during antenatal appointments before the request for an epidural is made. There is little research into how UK

maternity services are organised and delivered and how these services can be changed to improve the outcomes for disadvantaged women (Mastracoia and James Nwabinell, 2009).

Fetters et al (2007) used a mixed methods approach to seek out the opinions of Japanese speaking women living in America who had given advance consent during the antenatal period for epidural analgesia in labour; the purpose of which was to help women who desired epidural analgesia during labour to receive it. The survey was carried out following concerns from maternity staff that Japanese speaking women could not communicate effectively enough to offer valid consent. The outcomes from the study advocated that the majority of women found advance consent helpful and highlighted that women from other cultural groups who are isolated by language barriers may benefit from this process (Fetters et al, 2007). Women are no less autonomous when they are pregnant and birth plans created during the antenatal period should be treated as advanced directives (White and Seery, 2008). The key skill in working with women from minority groups is based on the midwife's ability to view each woman in her own right and not as someone ethnically distant (England and Morgan, 2012). Working in partnership and using a multidisciplinary approach is likely to improve access to maternity services and thus obstetric outcomes for ethnic minorities (Ameh and van de Broek, 2008).

For almost all pregnant women, the midwife is the main coordinator in her care throughout pregnancy to the postnatal period and is the centre of communication within the multidisciplinary team to suitably co-ordinate the care of women who require input from other services (Midwifery 2020 UK Programme, 2010; Price, 2013). Midwives need to make certain they can publically display good decision making as well as demonstrating client involvement in order to comply with national standards and guarantee the provision of quality patient care

(Barber, 2012). They have a duty of care to their mothers to ensure optimal analgesia is provided during labour (McGrady and Litchfield, 2004).

Women from immigrant backgrounds have the right to sensitive and adequate healthcare during the childbearing process regardless of their migrant status (Benza and Liamputtong, 2014).

However, good communication and care are not being currently met for these women in conventional services. This is coupled with the fact that suboptimal obstetric outcomes are more common in the migrant than the native population (Hayes et al, 2011). Midwives must act as advocates for the women in their care and are required by the NMC Code (2015) to make arrangements to meet their language and communication needs in order to ensure information is accurate and comprehensible. Ethnic minority women should be actively encouraged to participate in local Maternity Services Liaison Committees and more consideration should be given to advanced care directives in the antenatal period to ensure women's unique needs are attended to. It is evident that further continuing education and support for midwives is required to promote culturally appropriate care.

Key Sentences

- Evidence suggests that ethnic minority women often feel as though they do not have a voice within the United Kingdom maternity system
- Midwives have a pivotal role to help women whose first language is not English to be educated sufficiently to make informed choices about their care management during labour and birth
- Antenatal opportunities should be provided to discuss issues such as epidural anaesthesia and consideration of 'advance directives' for care should be considered should the situation arise where interpreting services are not available
- Ethnic minority women should be actively invited and encouraged to participate in Maternity Service Liaison Committees
- Midwifery models of care such as caseload should be considered for ethnic minority women to enhance the trusting relationship between a woman and her midwife

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